ATTACHMENT J1
(EXAMPLE 12)

ATTACHMENT J1 (Example)

DELTA DENTAL "Based on Section 22816.7 of the G nment Code"

Delta Den an of California

Enrollment — Voluntary

Group Name
State of California - Exempt Employees

Delta Group/Division Number
9949 - 8601

A ENROLLEE (Complete this section for new enrollment or change of status)

Name
Last First Middle Initial

Social Security Number
(Member I.D. Number)

Date Employed Effective
Month Day Year

Action Requested
☐ New enrollment ☐ Reinstatement
☐ COBRA enrollment ☐ Transfer
☐ Change in enrollment ☐ Rehire

Please enroll me in the following:
X
☒ Delta Dental
☐ Delta Vision

Birthdate
Month Day Year

Sex
Male
Female

Marital Status
Single
Married
Divorced
Separated

Do you have dependent children?
Yes
No

Does your spouse have a dental plan? ☐ Yes ☐ No
If yes, who is covered: ☐ yourself ☐ spouse ☐ dependent children
If Delta Dental, indicate group number:

Employee Classification N/A
☐ Certificated ☐ Full-time ☐ Part-time
☐ Classified ☐ Hourly ☐ Retired
☐ Salaried ☐ COBRA

Mailing Address
City
Telephone Number ( )
State ZIP code

FOR DELTA USE ONLY
Effective Date of Coverage
Family Indicator Code

COBRA Enrollment N/A
I understand that I may be required by the employer to pay for COBRA benefits

Note: If Dependent is enrolling under own social security number, the original Member's social security number must be supplied.

Benefits previously received under Social Security Number (Member I.D. Number)

Qualifying Date ____/____/____
Month Day Year

B Change to Existing Enrollment (Complete all sections that apply) N/A

Name change Add new dependent Delete dependent Address change listed above

Reason for change

Effective date of change ____/____/____
Month Day Year

C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Name
Last (if different) First Middle Initial

Child Name
Last (if different) First Middle Initial

Add/ Delete	Sex M F	Birthdate Month Day Year	Marriage/Divorce Date Month Day Year	Spouse's Social Security Number
		/ /	/ /	

Add/ Delete	Sex M F	Birthdate Month Day Year	If Child is 19 years or older (check one) Full-time Student	Disabled	Child's Social Security Number

D Signature (Form must be signed to be processed)

I understand that I may be required by the employer to pay for these benefits. I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

Enrollee Sign

Date

Delta 6024 (4-9)